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ABSTRACT

Although psychologists have played key roles in providing mental health services to rural populations for many years, only recently has the profession begun to devote more attention to the issues of psychologists who work in rural areas. Existing literature on rural mental health has focused primarily on unique problems of rural populations and the diagnosis and treatment of rural clients. The purpose of this study was to investigate the benefits and stressors of working in a rural setting (n=197). In addition, the study addressed how well psychologists' training prepared them for rural work and why they chose a career in rural mental health. Phone interviews with 17 psychologists were used to create the Rural Practice and Management Survey, an instrument reflective of the experiences of rural psychologists. Results indicated that rural mental health service providers were a fairly homogeneous group. They tended to be White males who were married, were trained in a clinical psychology program, and who were primarily employed in direct human services. The level of stress reported by this sample was in the low to low-moderate range. Overall, participants were very enthusiastic about the benefits of working in a rural mental health environment. Contains nine tables and three figures. (JBJ)

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BENEFITS AND CHALLENGES: EXPERIENCES OF RURAL PSYCHOLOGISTS

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Paper presentation for the 1995 annual American Psychological Association meeting in New York, NY

BENEFITS AND CHALLENGES: EXPERIENCES OF RURAL PSYCHOLOGISTS

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Introduction

Although psychologists have played key roles in providing mental health services to rural populations for many years, only recently has the profession begun to devote more attention to the issues of psychologists who work in rural areas. For example, in 1991, the American Psychological Association (APA) established the Rural Health Initiative to address issues which will be faced by rural professionals in the future, and the National Institute of Mental Health (NIMH) announced its new Office of Rural Mental Health Research (ORMHR) designed to fund research on rural mental health issues (Enright, 1994).

Existing literature on rural mental health has focused primarily on unique problems of rural populations and the diagnosis and treatment of rural clients. For example, using their Rural Experiences Questionnaire (REQ), Templeman, Condon, Starr, & Hazard (1989) discovered that some stressful life events for rural client populations correlated with depression. In contrast, much less research has been devoted to examining the experiences of rural mental health providers, especially psychologists. It has been noted that few trained professionals seem willing to work in rural areas and that few empirical studies address the benefits of providing psychological services for rural communities (Hargrove, 1991).

In contrast, other professions, such as psychiatry and social work, already have begun to investigate factors that affect the satisfaction, retention, and productivity of their rural mental health service providers. Reed (1992) observed that factors such as being somewhat isolated professionally, adapting to a different social culture, and lacking collegial relationships may serve as deterrents to recruiting psychiatrists to rural areas. However, she noted that these situations may serve as a "marvelous impetus" (p. 144) for the personal and professional growth of mental health service providers.

It is clear that the field of psychology would benefit from a greater understanding of the issues, both positive and negative, that are unique to rural psychologists. The purpose of this study was to investigate the benefits and stressors of working in a rural setting. In addition, the study addressed how well psychologists' training prepared them for rural work and why they chose a career in rural mental health.

Method

Participants

Survey packets were mailed to a random sample of 400 psychologists who were members of APA and whose work address had a rural zip code. The survey packets included a cover letter, survey questionnaire, stamped return envelope, and self-addressed postcard on which respondents could indicate that they completed and returned the questionnaire and whether they wanted a summary of the results. Two follow-up mailings were conducted. The final number of respondents was 312, representing a 78% return rate.

Of the 312 respondents, only 220 indicated that they considered themselves to be rural mental health service providers. Of that number, 197 were doctoral level and were included in the following analyses. The majority (62%) were male with an average age of 47 years. The racial or ethnic breakdown was: 88% White/Caucasian of European descent, 6% White/Caucasian of Middle Eastern descent, 2% Asian-American/Pacific Islander, 2% Other (including biracial) and 2% Latino/a. Less than 1% of the respondents were African-American/Black or Native American/Alaskan Native. Regarding marital status, 75% indicated that they were married or in a committed relationship while 11% were separated or divorced, 4% single (never married), and 1% widowed.

All respondents had earned doctoral degrees; 81% were PhDs, 11% PsyDs, 6% EdDs, and 2% other degrees. Over half graduated from clinical psychology programs (57%), and 21% came from

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counseling psychology programs. Twelve percent were from other programs (including joint programs), with 4% from school psychology and 4% from counselor education. When asked to report their APA divisional affiliation, 48% of the respondents gave no affiliation. The most popular divisions among participants were: Clinical Psychology (Div. 12), Psychologists in Independent Practice (Div. 42), Counseling Psychology (Div. 17), Psychotherapy (Div. 29), General Psychology (Div. 1), and Clinical Neuropsychology (Div. 40).

Primary employment settings included individual private practice (35%), community mental health center (13%), group psychological practice (10%), medical/psychological group practice (7%), psychology department (5%), and general hospital (5%). Most respondents reported holding positions involving direct human services (73%), administration of human services (14%), faculty (9%), and educational administration (1%). On a more personal level, 44% of the respondents indicated that they had grown up in a rural area.

Measure

The Rural Practice and Management Survey consists of 58 items combining checklist, Likert-type, and open-ended responses. The survey measures such factors as (a) how well training programs prepared respondents for work in rural areas, (b) how much stress was experienced as a result of aspects of rural work, (c) how frequently particular situations occurred, (d) benefits of being a rural mental health provider, (e) reasons why psychologists chose to work in rural mental health, and (f) likelihood of attending rural-related continuing education offerings.

In order to create a survey instrument reflective of the experiences of rural psychologists, the investigators first conducted phone interviews with 17 psychologists from various geographical areas in the U.S. These professionals were identified by APA as people involved in the practice and administration of rural psychology, and all 17 agreed to participate in the 20-30 minute interviews. They identified critical incidents they had encountered which represented ethical dilemmas, clinical practice and administrative issues, office and practice management concerns, legal issues, or other situations particularly relevant to a rural setting.

From these critical incident interviews and from our review of the literature, items descriptive of rural practice and management situations were constructed. These situations were then categorized by the research team into nine general themes (i.e. dual relationships, bartering, conflicts of interest, threats to confidentiality, rural client characteristics, lack of anonymity for rural providers, lack of resources, general stress for rural psychologists, and other). To confirm these themes, seven independent raters (all licensed psychologists) were asked to categorize the items into the nine themes. It was determined that an item fit a category if four or more raters agreed on the categorization. Using feedback from the independent raters, items that were unclear or difficult to categorize were eliminated or modified, resulting in a final pool of 53 situations which could be placed in one of seven categories or subscales (i.e. dual relationships, bartering, conflicts of interest, threats to confidentiality, rural client characteristics, lack of anonymity for rural providers, and lack of resources). Participants were asked to rate each situation on a 7-point Likert-type scale according to (a) the level of stress generated by the situation (1=not at all stressful; 7=extremely stressful) and (b) how frequently the situation occurred (1=never; 7=every day).

Results

First, means and standard deviations were computed for each item and each subscale or category with regard to frequency of occurrence and stress level.

Frequency of occurrence

Respondents did not report a high frequency of occurrence for any subscale. The subscales showing the least amount of frequency were: bartering (M=1.6), conflicts of interest (M=2.5), and threats to confidentiality (M=2.8). Subscales reflecting moderate frequency or rate of occurrence were: lack of anonymity (M=3.5), lack of resources (M=3.5), dual relationships (M=3.5), and rural client characteristics (M=3.6). To test whether there were differences among participant subgroups, multivariate analyses of

variance (MANOVAs) were run based on gender, race, marital status, graduate training specialty, and rural background of respondents. No significant differences were found, indicating that participants were very similar in their experiences across demographic variables.

Individual situations that occurred fairly frequently were: (a) feeling as if one were "living in a fishbowl" (M=4.8), (b) encountering former or current clients in public places (M=4.7), (c) clients feeling reluctant to seek treatment (M=4.5), (d) clients feeling concerned that others may discover he/she is in therapy (M=4.2), and (e) clients lacking understanding about psychotherapy (M=4.2).

Stress level

Upon examination of the level of stress experienced by respondents, only low to moderate ratings of stress were noted. Except for conflicts of interest (M=3.1) and lack of resources (M=3.3), all subscales were below a three for level of stress. Once again, MANOVAs assessing differences among participant subgroups showed no significant differences. In analyzing the stress level of individual items, the more stressful situations included: (a) demand for services interfering with family and recreation (M=4.3), (b) resources and services located at a distance (M=3.7), (c) reluctance to refer to other local providers who are perceived as incompetent (M=3.7), and (d) being asked to provide services beyond one's training and competency (M=3.6).

Stress level and frequency of occurrence

Only two specific situations seemed to occur with both fairly high stress level and fairly high frequency of occurrence. These were: (a) having resources and services located at a great distance (stress M=3.7, frequency M=4.0) and (b) experiencing demand for services which interfered with family or recreation time (stress M=4.3, frequency M=4.0).

Adequacy of preparation by training programs

When asked to report how adequately their training programs prepared them to work as a rural mental health service provider, interestingly, an equal number of respondents (22%) fell into opposing groups. One group reported being trained to a great extent in rural mental health issues, and the other indicated that they had not received any training in this area. Using a 7 point scale (1=not at all; 7=to a great extent) to rate their training in selected areas, respondents indicated receiving hardly any training in bartering (M=2.3), lack of anonymity (M=2.5), lack of resources (M=2.8), and rural client characteristics (M=2.9). However, their training did seem to address dual relationships (M=3.9), conflicts of interest (M=4.1), and threats to confidentiality (M=4.9).

Likelihood of attending rural-related continuing education

Although for most subscales, adequacy of preparation was low, respondents reported only a moderate likelihood (M=4.1) of attending continuing education activities in their region on topics of rural mental health practice and management.

Benefits of rural mental health and reasons for entering rural mental health

Responses to the open-ended questions "What do you believe are the benefits of being a rural mental health provider?" and "Why have you gone into rural mental health/" were both varied and interesting. Benefits that were cited most frequently were related to professional practice advantages (e.g., "working with people who seem more simple, sincere, and motivated to change," "collegiality between mental health and other caregivers," and "less competitive market."). In addition, a large number of respondents saw quality of life issues (e.g., "more relaxed lifestyle," "minimal traffic," "slower pace") as significant benefits of working in a rural setting. Other benefits cited were: the environment (e.g., "beautiful surroundings"), family advantages (e.g., "good place to raise kids"), serving underserved populations, belonging to a community, and getting respect and appreciation from others.

As for reasons for going into rural mental health, they varied from practice considerations (e.g., "tremendous challenge") to disliking cities and city features. The most common reason for going into rural mental health was the rural setting and lifestyle (e.g., "prefer living in a rural setting," "area was a great one to raise and educate my children").

Discussion and Conclusions

In this sample, rural mental health service providers were a fairly homogeneous group of psychologists. They tended to be White males who were married, were trained in a clinical psychology program, and who were primarily employed in direct human services. Also, the group was quite homogeneous in their report of stress level and frequency of occurrence for the various subscales. The actual level of stress reported by this sample was in the low to low-moderate range. The specific situations rated as providing the highest level of stress for the sample was experiencing demands for service which interfered with family and recreation activities. The most frequently occurring situations were: encountering clients in public places and finding area residents avoid treatment for psychological problems. Although in general some situations may have generated stress, it may be that the benefits of rural practice and lifestyle provide a balance to that stress.

Overall, participants were very enthusiastic about the benefits of working in a rural mental health environment even though for a few, their initial decision to go into a rural setting seemed somewhat unplanned and was based on serendipity, spouse/partner career, or job availability. However, the reasons most commonly cited by participants for going into rural mental health were related to the attractiveness of the rural setting and lifestyle (e.g., clear skies, clean air, relaxed attitudes, quality of life for self and family).

In response to the query "What are the benefits of being a rural mental health provider?," by far the greatest number of comments centered on professional practice advantages. Common benefits included: low overhead, less competition, greater autonomy, more collegial relationships with other professionals, and positive characteristics of the client population. Possibly, similar to Templeman et al.'s (1989) findings with rural client populations, positive rural experiences may be linked to lower levels of anxiety or depressions for psychologists.

This study is unique in that it provides a profile of psychologists who consider themselves rural mental health providers. The sample was random, and the return rate of 78% ensures its representativeness. One of the questions left unanswered by this study pertains to why other psychologists do not choose to work in rural settings. Given the lack of empirical attention to rural psychologists, there are many avenues for future study. The response rate to this study may reflect the eagerness of rural psychologists to be heard.

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Templeman, T.L., Condon, S., Starr, D., & Hazard, C. (1989). Stressful life events in rural settings. Journal of Rural Community Psychology, 10(1), 41-57.

For more information about this study, the investigators may be contacted at: University of Maryland at College Park, Counseling and Personnel Services Department, 3214 Benjamin Building, College Park, MD 20742.

Demographics (n=197)

Table 1
Gender

	n	%
Male	122	62
Female	74	38

Table 2
Race or Ethnicity

	n	%
African-Amer./Black	1	1
Asian-Amer./Pac. Islander	3	2
White/Cauc. of Europ. descent	174	88
White/Cauc. of Middle East. descent	12	6
Latino/a	3	2
Native Amer./Alaskan Native	1	1
Other (including biracial)	3	2

Note. Percentages do not add up to 100 due to rounding.

Table 3
Marital Status

	n	%
Single (never married)	7	4
Married/Committed relationship	147	75
Separated or divorced	22	11
Widowed	2	1

Note. Percentages do not add up to 100 due to missing data.

Table 4
APA Divisional Memberships - Seven Most Popular Responses

	n	%
No division membership or affiliation	95	48
Clinical Psychology (Div. 12)	28	14
Psych. in Indep. Practice (Div. 42)	22	11
Counseling Psychology (Div. 17)	15	8
Psychotherapy (Div. 29)	12	8
General Psychology (Div. 1)	12	6
Clinical Neuropsychology (Div. 40)	11	6

Note. Each respondent could indicate up to five divisional memberships.

Table 5
Highest Earned Degree

	n	%
Ed.D.	12	6
Ph.D.	160	81
Psy.D.	21	11
Other	4	2

Table 6
Graduate Program Specialty

	n	%
Clinical Psychology	112	57
Counseling Psychology	42	21
School Psychology	7	4
Counselor Education	7	4
Other (including joint programs)	24	12

Note. Percentages do not add up to 100 due to missing data.

Table 7
Grew up in a Rural Area

	n	%
Yes	87	44
No	109	55

Note. Percentages do not add up to 100 due to missing data.

Table 8
Means and Standard Deviations of Adequacy of Training in Specific Areas

	M	SD
Dual relationships	3.9	2.01
Bartering	2.3	1.86
Conflicts of interest	4.1	1.91
Threats to confidentiality	4.9	1.88
Rural client characteristics	2.9	1.74
Lack of anonymity for rural providers	2.5	1.62
Lack of resources	2.8	1.75

Note. 1=not at all, 4=moderately, 7=to a great extent

Table 9
Means and Standard Deviations of Subscales

	Stress Level		Frequency	
	M	SD	M	SD
Dual relationships	2.8	1.09	3.5	1.25
Bartering	2.4	1.27	1.6	0.80
Conflicts of interest	3.1	1.36	2.5	0.98
Threats to confidentiality	2.7	1.12	2.8	0.93
Rural client characteristics	2.7	0.97	3.6	1.01
Lack of anonymity for rural providers	2.9	1.15	3.5	1.14
Lack of resources	3.3	1.11	3.5	1.08

Note. For stress level, 1=not at all, 4=moderately, 7=extremely; for frequency, 1=never, 4=occasionally, 7=every day

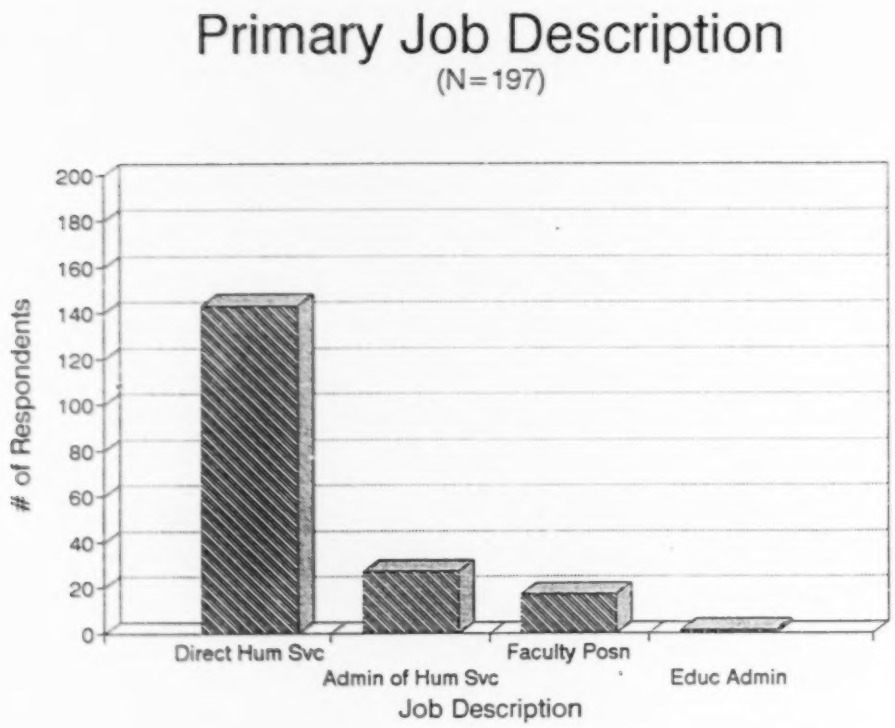

Figure 1. Primary job description of respondents.

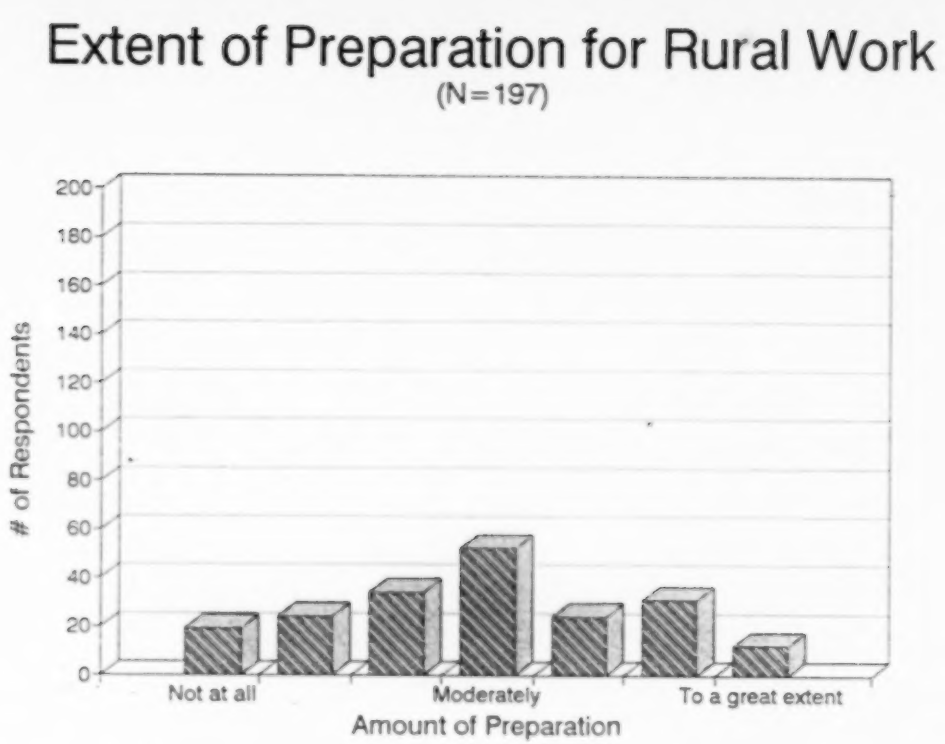

Figure 2. Extent to which graduate program prepared respondents for providing rural mental health services.

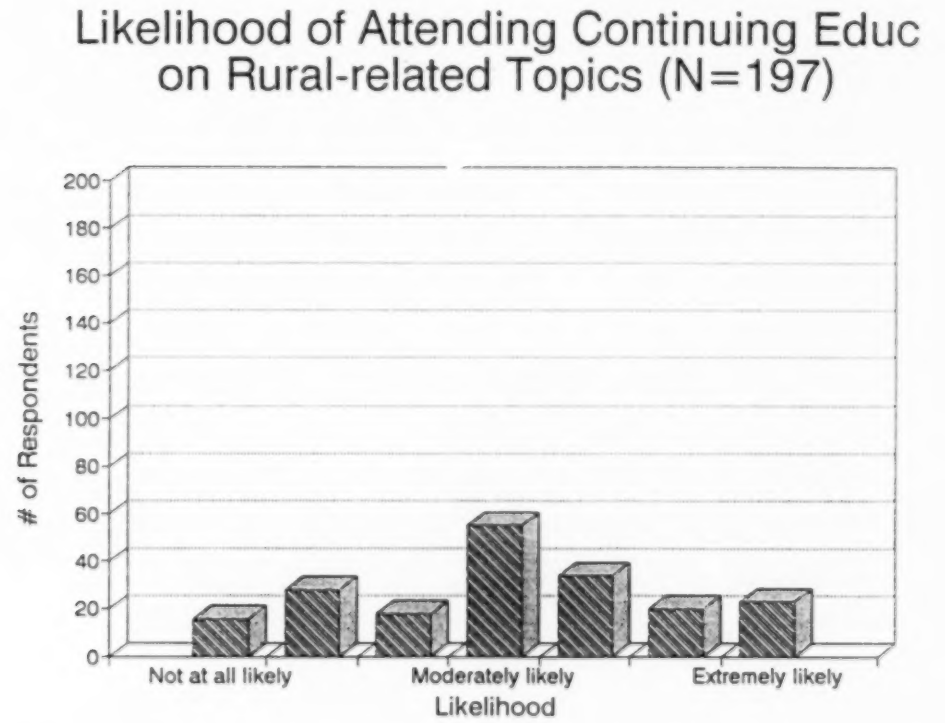

Figure 3. Likelihood of respondents attending rural-related continuing education activities.